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ABSTRACT

The author describes a psychoeducational model of services for learning disability (LD) students using the British Columbia public school system. The influence of biosocial and environmental factors such as pollution and use of obstetric medication which contribute to increasing numbers of LD students are discussed. Referral, individualized prescriptions for learning, and followup activities of a learning clinic program are described. (CL)

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A MODEL FOR THE DELIVERY OF SERVICE TO CHILDREN WITH LEARNING DISABILITIES: A GROWING INTERNATIONAL PROBLEM

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A MODEL FOR THE DELIVERY OF SERVICE TO CHILDREN WITH LEARNING DISABILITIES: A GROWING INTERNATIONAL PROBLEM

Scientific address to the problems of children with learning disabilities is a fairly recent phenomenon. Previously, these children were thought to be mentally retarded, emotionally disturbed, lazy, unmotivated, etc. During the last fifteen years, as we have become more aware of the specific nature of the problem, a growing technology of educational treatment and prescriptive techniques to help these children learn has been developed. In small pilot research projects, in private schools devoted to the purpose, and in special pockets of expertise in various places in the world, there have been important demonstrations that these procedures do work, and that these children can become successful learners, albeit in ways different from the majority of their class and age mates. Unfortunately, this knowledge, and especially the concomitant services to children, are not yet widespread.

This problem is not confined to any one locale, but exists throughout the world; it is a problem wherever a public school system attempts to teach children to read. The numbers of children affected in North America is anywhere from 5 to 20 per cent of the school-age population. Only a small percentage of these children are fortunate enough to receive the benefits of the technology now available.

In this paper, a model for delivery of service to children with learning disabilities has been described.

This service is based on a psycho-educational, rather than medical, model and is geared for widescale delivery through the public school system. It is based on sophisticated diagnosis and assessment of intellectual potential achievement level, functioning of the visual and auditory modalities, and learning style. It develops a long and short range individual educational strategy in conjunction with the child's school, teachers and parents. It provides long-term educational follow-up and evaluation of progress.

The learning disabled child is a growing international phenomenon, and the contribution of psychology to its solution is potentially important.

A MODEL FOR THE DELIVERY OF SERVICE TO CHILDREN WITH LEARNING DISORDERS

Introduction

Were you aware that from the time a child is 6 years old, he spends almost 60% of his waking hours during the week in the business of learning? To have difficulty with that learning is a problem of paramount importance to the child. It affects his life, his emotional and social development, his family and peer relations, the development of his intelligence, his sense of competence as a person - his self esteem - and finally, his academic achievement.

In North America, where all children of 6 years are expected to learn to read in a public school classroom with 30 others, those who do not process this kind of information at the same rate and in the same manner as their peers are at a critical disadvantage - and this disadvantage remains with them throughout their schooling, increasing in severity as the gap between them and their agemates increases.

Unfortunately, there are enormous numbers of these children. In North America, statistics range anywhere from 5 to 20% of school age children. Even being conservative, it is likely that in every classroom in the country, there 2 or 3 children who have difficulty learning what the teacher is trying to teach. In heavily industrialized urban centres, where biosocial and environmental factors compound the problem, and schooling is less personal, the numbers are greater.

I. In recent years the numbers of these children appear to be increasing. Many subtle biosocial and environmental factors contribute to this.

1. As medical technology advances, a much higher percentage of high risk newborns survive. Unfortunately, they often do so with rather subtle minimal brain dysfunction which results in behaviors like irritability, destructiveness, mood swings and temper tantrums,

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hyperactivity, and at school age, learning difficulties. As well, these improvements in technology often prevent severe handicaps which formerly resulted in gross mental retardation - 6 years later, these survivors of the intensive care nurseries line up at the doors of facilities for Special Education wherever they may be. Even more unfortunately, some of these disabilities are not detected until many years of school failure have warped the development of their personalities, and the destructive social consequences for the entire community becomes evident.

2. Increased environmental pollution, both from industrial sources and emission of automobiles, have increased by 400 times the amount present in pre-industrial times. In the last 25 years, the increase has again accelerated at enormous rates. New data from studies using the dentine level of baby teeth (Needleman et.al., at Harvard, 1979) and hair (Pihl and Parkes, at McGill, 1977), as well as blood, have pointed to the toxic effect to the central nervous system of much lower levels of lead per milliliter of blood than was previously considered safe. The environmental effect is strongest when the developing child is most vulnerable - that is, in utero and during the earliest years.

3. We are also beginning to discover the frightening statistics of damage to the newborn by smoking, alcohol and drugs, by mothers and even fathers.

4. As the data is gathered we learn that even advancing technology is not an unmixed blessing.

For example, many more children are born in hospitals where obstetric medication is in widespread use. Until recently, it was assumed that the placenta screened out any toxic element. New studies, however, indicate that drugs cross the placenta rapidly and lodge in brain centres that are at high risk for damage, since they are unmyelinated and still developing. The cerebellum and

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hippocampus are particularly vulnerable. In a report to the U.S. Senate Subcommittee on Health in 1978, Broman and Bruckhill found in a longitudinal study on more than 50,000 babies that obstetric medication affected behaviors at least to 7 years, and it appeared likely that the damage was permanent. Affected behaviors included gross motor ability to stand and sit; later inhibitory behaviors - to stop responding - e.g. to stop crying when comforted; language development; task oriented behavior; etc.

5. Thus, in addition to <u>better screening devices</u> for young children, of the type Paul Satz has been developing,

6. and <u>more recognition</u> of the concept of learning disabilities <u>by the public education system</u>, we are better able to identify learning difficulties at earlier ages. It is not our imagination that the numbers of these children are also increasing.

When considering the development of services, these numbers are an important consideration. Other maladies and handicaps of children have limited populations. Thus, if one needs to develop services for cerebral palsied, deaf or autistic children, a limited amount of services is required. But, if in a school age population of 100,000 children, 10 - 15,000 need special services, the model for service delivery must take this into account.

II. <u>Analysis of services to learning disabled children in B.C. in 1977-78</u> revealed a problem probably typical of most North American cities, except where centres of expertise have grown up around excellent university teams, e.g. Montreal, Boston, Syracuse (N.Y.), etc.

1. <u>Teachers</u>, even those in the Special Education area, <u>had little training</u> in dealing with these children. In a survey done by the Vancouver Association for Children with Learning Disabilities (VACLD) in 1979, of teachers associated with the Vancouver School Board - the Board with the most extensive special services in B.C. - 68% of

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the teachers in the Special Education Service did not have a single course in Learning Disabilities and more than 50% did not have any training in teaching Developmental Reading. Reasons for appointing teachers for these positions were varied, but were often not based on teacher expertise or even special interest in the area.

2. Medical facilities were heavily overloaded with requests to see these children, however, even in the most sophisticated multi-disciplinary diagnosis, the psychologists used a limited number of standardized tests, which militated against the success of learning disabled children and, often misdiagnosed them as borderline retarded. It did not even provide baseline data on which to develop programs. Thus, a diagnosis and series of suggestions was often filed with the appropriate authorities, but led to no further services for the child. In fact, the new label provided by the diagnosis was often detrimental and led to fewer services provided as well - lowered expectancy for the child led to less learning, lowered self esteem, etc.

3. The weakest link in the medical model was the follow-up system which in most cases was non-existent or consisted of a form letter sent a year later to check on whether anything was done for the child.

Children emerged from these extensive diagnostic procedures no further ahead than when they began. Their teachers did not know more about how to teach them nor did their parents learn how to cope.

Thus, the model I am about to describe was designed to fill the gap between the diagnosis and the outcome for the child. It also takes into account that:

- the numbers of children involved will be large;
- the child's teachers will have relatively little previous training or skill;
- the problem will take several years of schooling to resolve (one can't take a pill and cure a learning disability;

- each child's problem is likely to be different and will require an individualized solution (unlike measles, etc., the same medicine may not work for everybody);
- the child's teachers and parents must be fully included in the process;
- the child himself must be motivated to succeed.

This model is set in a university associated Children's Hospital, although it should be noted that this need not be the case.

It has a tripartite function:

1) As a centre of expertise for the direct delivery of service for the most severely disabled;
2) As a training centre for highly qualified professionals, in particular for those in the interdisciplinary areas of psychology and education;
3) As a research centre for both theoretical and applied research.

The Learning Clinic Program

The referral process should provide the widest possible access of children to the service. Thus, referrals through physician, teacher or parent would be appropriate. At the Children's Hospital, we are restricted to medical referrals, but this is often just a formality.

Before the child arrives an information gathering system provides a rich data base on all previous assessment and interventions and also outlines the scope of the problem.

The first visit is carefully staged by an assistant to be an important event. Teachers, parents and other workers involved with the child are invited to participate fully. The scene is set and expectations for change are underlined.

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During the preconference, each of the participants outlines his main concerns and objectives for the visit. It is most crucial that, having stated these, they leave feeling that the main issues have at least been addressed. The process to follow is described, and the group is told that a prescription to optimize learning will be provided.

The child is included in every aspect, and this is part of the therapy. It is important whether he is 6 or 16 that the child know in his own terms what the problem is, and how it can be dealt with.

The child and psychologist proceed to a room with a one-way mirror. If he is old enough - 10 or more - he is told ahead of time that his parents and teachers are watching. Younger children are shown the observers at the end of the assessment. It is presented as if they have been on T.V. and now everyone is aware of how well they can do. Since the tests begin at lower levels to establish baselines, all children can feel they have had some success. The issue of having been observed is always dealt with before the child leaves. The assessment explores in an informal, yet sophisticated way, the child's overall level of cognitive and language functioning, his achievement level in reading, spelling and arithmetic, and the functioning of the auditory and visual input and motor systems, to determine:

- whether a learning disability is interfering with performance;
- where the baselines are in academic achievement;
- where the problem might be along the input system, i.e. discrimination, perception, memory, processing, integrating, motor output, etc.

An individualized prescription for learning is developed for each child in conjunction with his parents and teachers and presented orally along with the results immediately after the conference.

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New strategies are demonstrated to see if the child is successful in using them. The child, his parents, and teachers are motivated by the psychologist's manner of presentation to work together and to report back in a month on how the program is working.

A detailed report outlines the procedures in written form. Prepared program outlines in written form are given to the teachers and parents whenever that is appropriate. Thus, they emerge with instructions on how to begin in a concrete form.

A post conference is held immediately after the session.

This is a crucial part of the process and the greatest clinical skill is required in imparting information to all concerned in such a way that the teachers and parents are informed of the results of the tests they have just observed and that the child who is the centre of all this learns that his problem can be dealt with and that the others present are ready and willing to help him. His successes and his basic ability to cope are stressed.

New strategies for learning are demonstrated in such a way that the child can have at least a small success. It is crucial that this portion be image enhancing to the child and that he leaves feeling motivated to work on his problem.

The Follow-Up

Unlike many other diagnostic centres, the process just described is the beginning rather than the end of the procedure. The first follow-up telephone conference is arranged for a month later at the session itself. Children with learning disabilities have long-term problems in school. Once they become an active patient, they are followed regularly from 3 to 6 months through telephone contact. At any time after that, they

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may re-initiate help whenever it is required as they change classes, schools, teachers or hit a crisis period. School visits and further consultation are arranged whenever the distance is viable and the need is present.

It is often the case that the psychologist needs to play a child advocacy role with the teachers, school or even the parents. This too is considered part of the function of the clinic.

It was indicated at the beginning of this paper that the number of learning disabled children was great and that we needed to address this issue in the plan for service delivery. If a highly trained professional psychologist attempts to provide only direct service he will quickly drown in the sea of requirements. The only solution is what I call the ripple effect which can be done by training both highly qualified professionals through practica and internships, and by using in-service in the form of university credit courses in the evening and summer to train teachers already working in the system.

Nor can we progress without rigorous and solid evaluation of what we do on an ongoing basis. Solid outcome in terms of improved performance and more positive affect from the child needs to be regularly assessed.

Thus, what has been described is a model to step into the gap between diagnosis in the form of test scores and the outcome for the child. We ask ourselves constantly at our Centre - what have we done to change this child's life - to make him more comfortable with the way he learns - to outline strategies that will optimize his potential to learn - and thus to make him feel better about himself.

A child with a learning disability has a very important problem. Consider how you would feel if every day of your life you could not do

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what your friends and colleagues could do eagerly, easily and with enthusiasm. If a visit to our Centre is successful, the child must emerge feeling that he can cope with this - that he is not dumb, and most importantly, that he can learn. In the end, the most important thing we sell is hope - hope that he too will learn to be a good learner.